



The purpose of this form is to document the action taken by an agency to review an incident on a person involved in a fall resulting in an injury to determine *WHY* the fall happened, to provide information on any recommendations to assure the future safety of the person and for prevention and quality improvement activities within the organization. An investigation will be conducted for any incident in which there is suspicion of abuse, etc. involving a fall/injury to a person. This form will be utilized for incidents which do not involve possible abuse.

Name of Person Involved in Incident: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Name of Agency: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Incident: \_\_\_\_\_ Location: \_\_\_\_\_

1. Did this person have any history of falls resulting in an injury in the last six months?  
no            yes (Provide dates, description of what happened and cause)

*Did this person have a previous PT assessment or fall protocol?*      no      yes

Is a description of the type of *assistance* needed included in his/her *Individual Support Plan*?

no          yes

3. Type of injury: \_\_\_\_\_ Abrasion      \_\_\_\_\_ Bruise/Contusion      \_\_\_\_\_ Concussion  
                          \_\_\_\_\_ Fracture      \_\_\_\_\_ Laceration      \_\_\_\_\_ Sprain  
                          \_\_\_\_\_ Burn      \_\_\_\_\_ Other

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5. Were there any direct witnesses to the injury or fall? \_\_\_no \_\_\_yes

6. What is the **primary cause** of **why** this incident happened?

**A. Environmental**

\_\_\_ Lighting      \_\_\_ Flooring (type)      \_\_\_ Conditions (slippery, clutter, etc.)  
\_\_\_ Electrical      \_\_\_ Other Safety Hazard (Explain:)

**B. Equipment**

\_\_\_ Lack of adaptive devices      \_\_\_ Faulty/not working  
\_\_\_ Person did not use equipment/device that was prescribed

**C. Physiological**

\_\_\_ Medical/health      \_\_\_ Mobility/balance issue  
\_\_\_ Vision      \_\_\_ Recent medication changes  
\_\_\_ Seizure      \_\_\_ Other (*Specify*)

**D. Behavioral**

\_\_\_ Carelessness      \_\_\_ Behavioral Incident  
\_\_\_ Lack of understanding of risk      \_\_\_ Involvement of other person  
with a disability

**E. Staff**

\_\_\_ Staff Unavailable      \_\_\_ Lack of Training  
\_\_\_ Carelessness      \_\_\_ Other (*Specify*)

Explain in more detail the primary cause: \_\_\_\_\_

**C. Follow-Up Action**

7. Is there any follow-up care that needs to be provided by the agency nurse, person's licensed health care provider or PT? \_\_\_no \_\_\_yes

Describe: \_\_\_\_\_

8. Are there any environmental changes that will need to be made? \_\_\_no \_\_\_yes

Describe: \_\_\_\_\_

9. Did your agency's Incident Management Committee have any recommendations regarding this incident? \_\_\_no \_\_\_yes

Describe: \_\_\_\_\_

10. Will this person's Individual Plan, Nursing Plan of Care or PT Plan need to be amended to reflect any changed services/supports as a result of this incident?    \_\_\_ no    \_\_\_ yes

11. What is the Safety Plan to assure this person will be safe from future falls/injuries?

12. Are there administrative actions that will be or have been taken as a result of this incident?  
\_\_\_ no    \_\_\_ yes    Please check as appropriate.

___ Policy Revisions	___ Staff Training
___ Procedural Changes	___ Medical/Health Follow-up
___ Personnel Action	___ Environmental Modifications
___ Individual Plan Revisions	___ Individual Assessments
___ Other ( <i>Specify</i> ) _____	

Describe action taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *Nam*

*e(s) of person(s) responsible for implementation:*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Name of Person Completing this Form: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Revised 2/2/05 Revised 6/23/08

***For Use by the Division of Developmental Disabilities and/or MHRH Only***

Date of Receipt: \_\_\_\_\_ Date of Approval: \_\_\_\_\_

Reviewed, as necessary, by:

\_\_\_ Office of Quality Assurance, DDD, Date: \_\_\_\_\_ Health Care, DDD Date: \_\_\_\_\_

\_\_\_ Incident Management Committee, DDD, Date: \_\_\_\_\_

Any Further Action: \_\_\_\_\_

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